		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001099

Facility Name: HILLCREST HOME

Address: 14734 ILLINOIS HWY 82 (Number) GENESEO (City) 61254 (Zip Code)

County: HENRY

Telephone Number: (309) 944-2147 **Fax #** (309) 944-8417

IDPA ID Number: 36-6001257001

Date of Initial License for Current Owners: 6/10/56

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JAMES E. TAYLOR **Telephone Number:** (309) 762-3626

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/02 to 11/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARY BERGREN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) JAMES E. TAYLOR, MEMBER
(Firm Name & Address) CARPENTIER, MITCHELL, GODDARD & CO., LLC, 4915 21ST AVENUE A, MOLINE, IL 61265
(Telephone) (309) 762-3626 Fax # (309) 762-4465

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 9/29/99

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3	74	Intermediate (ICF)	74	27,010	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	662	1,186	478	2,326	8
9	SNF/PED					9
10	ICF	24,105	16,779		40,884	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,767	17,965	478	43,210	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.77%

D. How many bed-hold days during this year were paid by Public Aid? 121 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/10/53

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 1,756

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/03 Fiscal Year: 11/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	319,210	14,356	10,501	344,067		344,067		344,067			1
2	Food Purchase		182,395		182,395		182,395	(2,545)	179,850			2
3	Housekeeping	145,580	6,726	389	152,695		152,695		152,695			3
4	Laundry	93,878	12,372	33	106,283		106,283		106,283			4
5	Heat and Other Utilities			163,424	163,424		163,424	(5,957)	157,467			5
6	Maintenance	91,381	17,062	45,490	153,933		153,933		153,933			6
7	Other (specify):*											7
8	**TOTAL General Services**	650,049	232,911	219,837	1,102,797		1,102,797	(8,502)	1,094,295			8
	B. Health Care and Programs											
9	Medical Director			150	150		150		150			9
10	Nursing and Medical Records	1,952,304	155,498	33,760	2,141,562	(5,124)	2,136,438	3,448	2,139,886			10
10a	Therapy	93,193	26	140,709	233,928		233,928	(239,964)	(6,036)			10a
11	Activities	52,942	1,930	27	54,899		54,899	(376)	54,523			11
12	Social Services	52,847	42	1,278	54,167		54,167		54,167			12
13	Nurse Aide Training					5,124	5,124		5,124			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,151,286	157,496	175,924	2,484,706		2,484,706	(236,892)	2,247,814			16
	C. General Administration											
17	Administrative	58,122			58,122		58,122		58,122			17
18	Directors Fees											18
19	Professional Services			30,430	30,430		30,430		30,430			19
20	Dues, Fees, Subscriptions & Promotions			11,225	11,225		11,225	(4,271)	6,954			20
21	Clerical & General Office Expenses	143,052	11,402	46,379	200,833		200,833	(15,596)	185,237			21
22	Employee Benefits & Payroll Taxes			732,437	732,437		732,437	(1,993)	730,444			22
23	Inservice Training & Education			584	584		584		584			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,721	110,721		110,721		110,721			26
27	Other (specify):*											27
28	**TOTAL General Administration**	201,174	11,402	931,776	1,144,352		1,144,352	(21,860)	1,122,492			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,002,509	401,809	1,327,537	4,731,855		4,731,855	(267,254)	4,464,601			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLCREST HOME #0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			214,445	214,445		214,445	(35,686)	178,759			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			214,445	214,445		214,445	(35,686)	178,759			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,700	2,700		2,700	(1,996)	704			38
39	Ancillary Service Centers			202,546	202,546		202,546	(58,642)	143,904			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		6,734		6,734		6,734	(6,734)				41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		6,734	303,796	310,530		310,530	(67,372)	243,158			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,002,509	408,543	1,845,778	5,256,830		5,256,830	(370,312)	4,886,518			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,545)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,957)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,993)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,272)	21		24
25	Fund Raising, Advertising and Promotional	(4,271)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(340,274)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (370,312)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (370,312)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

HILLCREST HOME

ID# 0001099

Report Period Beginning: 12/01/02

Ending: 11/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MEDICARE REIMBURSEMENTS	$ (58,642)	39	1
2	TELEPHONE CALLS CHARGED TO PATIENTS	(229)	21	2
3	TRANSPORTATION	(1,996)	38	3
4	OXYGEN REIMBURESEMENT	3,448	10	4
5	ACTIVITIES FEES	(376)	11	5
6	THERAPY REIMBURSEMENTS	(239,964)	10a	6
7	VENDING MACHINE	(6,734)	41	7
8	DEPRECIATION ADJUSTMENT	(35,686)	30	8
9	MISC GENERAL OFFICE EXPENSE	(95)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(340,274)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,545)	0	0	0	0	0	0	0	0	0	0	(2,545)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,957)	0	0	0	0	0	0	0	0	0	0	(5,957)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,502)	0	0	0	0	0	0	0	0	0	0	(8,502)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	3,448	0	0	0	0	0	0	0	0	0	0	3,448	10
10a	Therapy	(239,964)	0	0	0	0	0	0	0	0	0	0	(239,964)	10a
11	Activities	(376)	0	0	0	0	0	0	0	0	0	0	(376)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(236,892)	0	0	0	0	0	0	0	0	0	0	(236,892)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,271)	0	0	0	0	0	0	0	0	0	0	(4,271)	20
21	Clerical & General Office Expenses	(15,596)	0	0	0	0	0	0	0	0	0	0	(15,596)	21
22	Employee Benefits & Payroll Taxes	(1,993)	0	0	0	0	0	0	0	0	0	0	(1,993)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(21,860)	0	0	0	0	0	0	0	0	0	0	(21,860)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(267,254)	0	0	0	0	0	0	0	0	0	0	(267,254)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HILLCREST HOME # 0001099 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(35,686)	0	0	0	0	0	0	0	0	0	0	(35,686)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(35,686)	0	0	0	0	0	0	0	0	0	0	(35,686)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(1,996)	0	0	0	0	0	0	0	0	0	0	(1,996)	38
39	Ancillary Service Centers	(58,642)	0	0	0	0	0	0	0	0	0	0	(58,642)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(6,734)	0	0	0	0	0	0	0	0	0	0	(6,734)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(67,372)	0	0	0	0	0	0	0	0	0	0	(67,372)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(370,312)	0	0	0	0	0	0	0	0	0	0	(370,312)	45

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HENRY COUNTY, ILLINOIS	100	NONE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	N/A	8
1999	N/A	9
2000	N/A	10
2001	N/A	11
2002	N/A	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLCREST HOME COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0001099

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,394 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	6 ACRES	VARIOUS	$ 1,000	1
2					2
3	TOTALS	#VALUE!		$ 1,000	3

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	158		1971	1971	$ 415,304	$ 8,306	50	$ 8,306	$	$ 259,781	4
5	22		1976	1976	1,064,182	21,283	50	21,283		591,120	5
6											6
7											7
8											8
	Improvement Type**										
9	GENERAL			1977	52,950	1,059	50	1,059		28,593	9
10	GENERAL			1979	6,552		3			6,552	10
11	GENERAL			1980	14,609	292	50	292		6,865	11
12	GENERAL			1981	61,074	1,222	50	1,222		27,480	12
13	GENERAL			1982	6,189		3			6,189	13
14	GENERAL			1983	79,248	1,317	.10-50	1,317		45,425	14
15	GENERAL			1984	46,106	847	.10-50	847		20,251	15
16	GENERAL			1985	76,531	1,692	.20-30	1,692		37,411	16
17	GENERAL			1986	76,930	2,610	.20-30	2,610		46,846	17
18	GENERAL			1987	120,391	4,013	30	4,013		67,969	18
19	GENERAL			1988	70,622	2,055	.12-40	2,055		34,148	19
20	GENERAL			1989	209,235	7,378	.20-40	7,378		106,764	20
21	GENERAL			1990	810,969	27,032	30	27,032		518,791	21
22	GENERAL			1991	336,390	11,213	30	11,213		210,578	22
23	GENERAL			1992	121,611	5,920	.5-20	5,920		71,279	23
24	GENERAL			1993	57,379	2,400	.5-20	2,400		37,663	24
25	GENERAL			1994	106,380	6,200	.10-20	6,200		58,895	25
26	GENERAL			1995	106,336	4,592	.10-40	4,592		42,749	26
27	RECOAT ROOF			1996	2,495	125	20	125		906	27
28	LIGHT FIXTURES			1996	1,855	185	10	185		1,394	28
29	HAND RAILS			1996	1,669		5			1,669	29
30	TUCK POINTING			1996	8,272	414	20	414		3,139	30
31	GARAGE			1997	5,708	142	40	142		911	31
32	AIR CONDITIONING			1997	35,751	1,787	20	1,787		11,174	32
33	COOLER			1997	18,258	913	20	913		6,239	33
34	BUILDING LIGHTS			1997	1,517		5			1,517	34
35	ROOF			1997	4,620	154	30	154		1,001	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PUMP HOUSE REPAIRS	1997	$ 800	$ 40	20	$ 40	$	$ 273	37
38	EXPAND LAGOON SYSTEM	1998	370,488	12,350	30	12,350		83,359	38
39	BOILER REPAIRS	1998	1,649	165	10	165		825	39
40	WATER HEATER	1998	3,550	355	10	355		2,071	40
41	ROOF	1998	5,477	274	20	274		1,507	41
42	GUTTERS	1998	5,767	288	20	288		1,704	42
43	EXPAND LAGOON SYSTEM	1999	46,155	2,308	20	2,308		9,787	43
44	BOILER REPAIRS	1999	23,138	2,314	10	2,314		9,256	44
45	HEATING MOTOR	1999	3,000	300	10	300		1,400	45
46	PARKING LOT LIGHTS	1999	1,284	128	10	128		640	46
47	CARPET	2000	2,626	262	10	262		854	47
48	WATER LINE REPAIR	2000	620	62	10	62		202	48
49	REFURBISH WASHERS	2000	3,168	317	10	317		1,136	49
50	A/C REPAIR	2000	6,781	678	10	678		2,373	50
51	WATER HEATER REPAIR	2000	5,425	542	10	542		2,035	51
52	REMODELING	2001	8,630	432	20	432		1,152	52
53	CONCRETE WORK	2001	1,512	151	10	151		315	53
54	GAS LINE REPAIR	2001	21,529	2,153	10	2,153		5,203	54
55	A/C REFURBISH	2001	4,169	417	10	417		1,112	55
56	HEAT REFURBISH	2001	7,859	786	10	786		1,965	56
57	WATER HEATER	2001	6,488	649	10	649		1,676	57
58	WATER HEATER	2001	5,551	555	10	555		1,573	58
59	A/C REFURBISH	2002	8,661	866	10	866		1,299	59
60	HEATER REFURBISH	2002	6,994	699	10	699		1,049	60
61	WATER HEATER	2002	2,562	256	10	256		299	61
62	SATELLITE	2002	14,037	1,404	10	1,404		1,755	62
63	IRON PUMP	2002	1,386	138	10	138		277	63
64	SHOWER ROOM REPAIR	2002	3,096	309	10	309		593	64
65	KITCHENETTE ADDITIONS	2002	2,270	227	10	227		435	65
66	KITCHENETTE ADDITIONS	2002	4,021	402	10	402		603	66
67	GARAGE PAINTING	2002	1,670	167	10	167		223	67
68	HOUSEKEEPING OFFICE ADDITION	2002	2,161	216	10	216		378	68
69	PRIVATE ROOMS REPAIR	2002	7,441	744	10	744		1,116	69
70	TOTAL (lines 4 thru 69)		$ 4,509,098	$ 144,105		$ 144,105	$	$ 2,391,744	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,509,098	$ 144,105		$ 144,105	$	$ 2,391,744	1
2	WHIRLPOOL SYSTEM	2003	10,311	687	10	687		687	2
3	ELEVATOR REPAIR	2003	3,300	165	10	165		165	3
4	SATELLITE	2003	500	21	10	21		21	4
5	BUILDING SHUTTERS	2003	872	22	10	22		22	5
6	BLACKTOP DRIVEWAY	2003	9,887	330	10	330		330	6
7	PERGOLA ENTRYWAY	2003	3,433	143	10	143		143	7
8	REFURBISH RESIDENTS ROOMS	2003	15,698	262	10	262		262	8
9	A/C & HEAT REPAIR	2003	1,000	33	10	33		33	9
10	REFURBISH HEAT & A/C	2003	17,570	1,025	10	1,025		1,025	10
11	REMODEL SMOKING ROOMS	2003	9,131	685	10	685		685	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,580,800	$ 147,478		$ 147,478	$	$ 2,395,117	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 300,050	$ 29,626	$ 29,626	$		$ 160,836	71
72	Current Year Purchases	33,901	1,238	1,238			1,238	72
73	Fully Depreciated Assets	651,839					651,839	73
74								74
75	TOTALS	$ 985,790	$ 30,864	$ 30,864	$		$ 813,913	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT TRANSPORT	1996 CHEVY VAN	1996	$ 34,005	$	$	$		$ 34,005	76
77	PATIENT TRANSPORT	2001 DODGE CARAVAN	2003	25,000	417	417		5	417	77
78										78
79										79
80	TOTALS			$ 59,005	$ 417	$ 417	$		$ 34,422	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,626,595	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,759	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 178,759	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,243,452	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	91 LUMINA/1991	$ 11,952	$	$ 11,952	86
87	94 CHEVY VAN/1994	18,472		18,472	87
88	97 LUMINA/1997	15,135		15,135	88
89					89
90					90
91	TOTALS	$ 45,559	$	$ 45,559	91

G. Construction-in-Progress

	Description	Cost	
92	BRICK SIGN	$ 674	92
93	SHOWER ROOM TUBS	500	93
94			94
95		$ 1,174	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[X]
HOURS PER AIDE	94

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
HOURS PER AIDE	41

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$ 3,144	$ 1,572	$	$ 4,716
2	Books and Supplies		272	136		408
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 3,416	$ 1,708	$	$ 5,124
10	SUM OF line 9, col. 1 and 2	(e)	$ 5,124			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	6
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

HILLCREST HOME
ID# 0001099

YEAR ENDED 11/30/03

SCHEDULE XIII - NURSE AIDE TRAINING

COMMUNITY COLLEGE FOR WHICH AIDES WERE TRAINED:

BLACKHAWK COLLEGE
1501 IL HWY 78
KEWANEE, IL 61443

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number HILLCREST HOME # 0001099 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,299,300	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,000)	532,717		3
4	Supply Inventory (priced at)	34,387		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SEE ATTACHED	3,782		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,870,186	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,000		13
14	Buildings, at Historical Cost	5,153,793		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,090,353		16
17	Accumulated Depreciation (book methods)	(3,582,481)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,662,665	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,532,851	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 137,285	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,496		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 351,781	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 351,781	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,181,070	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,532,851	$	48

***(See instructions.)**

HILLCREST HOME
ID#0001099

YEAR ENDED 11/30/03

SCHEDULE XV - BALANCE SHEET

LINE 9 - OTHER CURRENT ASSETS

	AMOUNT
PREPAID EXPENSE	601
ACCRUED INTEREST	3181
TOTAL	3782

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,084,217	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,084,217	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(432,268)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (432,268)	17
	B. Transfers (Itemize):		
18	**FICA REIMBURSEMENT**	226,269	18
19	**IMRF REIMBURSEMENT**	79,452	19
20	**INSURANCE REIMBURSEMENT**	223,400	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 529,121	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,181,070	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,391,560	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,391,560	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	239,964	6
7	Oxygen	(3,448)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 236,516	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	25,308	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,545	14
15	Telephone, Television and Radio	229	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 28,082	23
	D. Non-Operating Revenue		
24	Contributions	14,732	24
25	Interest and Other Investment Income***	20,104	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,836	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SEE ATTACHED SCHEDULE	133,568	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 133,568	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,824,562	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,102,797	31
32	Health Care	2,484,706	32
33	General Administration	1,144,352	33
	B. Capital Expense		
34	Ownership	214,445	34
	C. Ancillary Expense		
35	Special Cost Centers	211,980	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,256,830	40
41	**Income before Income Taxes (line 30 minus line 40)****	(432,268)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (432,268)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

HILLCREST HOME
ID#0001099

YEAR ENDED 11/30/03

SCHEDULE XVII - INCOME STATEMENT

E. OTHER REVENUE

	AMOUNT
MEDICARE PHARMACY PART A	51,943
MEDICARE LAB	2,176
MEDICARE RADIOLOGY	426
MEDICARE MISCELLANEOUS PART B	1,020
MEDICARE ME SUPPLIES PART A	3,076
VENDING MACHINE	14,190
NURSING SUPPLIES	47,946
TRANSPORTATION	1,996
ACTIVITIES FEES	376
MISCELLANEOUS	10,419
TOTAL	133,568

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,765	2,080	$ 55,226	$ 26.55	1
2	Assistant Director of Nursing	1,726	2,080	51,202	24.62	2
3	Registered Nurses	9,654	11,325	229,280	20.25	3
4	Licensed Practical Nurses	31,500	36,824	584,158	15.86	4
5	Nurse Aides & Orderlies	91,503	101,332	961,500	9.49	5
6	Nurse Aide Trainees	1,131	1,389	11,604	8.35	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,429	6,300	52,803	8.38	10
11	Social Service Workers	3,547	4,144	52,701	12.72	11
12	Dietician					12
13	Food Service Supervisor	3,645	4,160	61,413	14.76	13
14	Head Cook	3,467	4,256	40,177	9.44	14
15	Cook Helpers/Assistants	25,844	26,241	216,656	8.26	15
16	Dishwashers					16
17	Maintenance Workers	8,726	10,401	102,338	9.84	17
18	Housekeepers	14,812	16,994	145,211	8.54	18
19	Laundry	9,351	11,371	97,036	8.53	19
20	Administrator	1,820	2,080	57,960	27.87	20
21	Assistant Administrator					21
22	Other Administrative	10,176	11,674	142,683	12.22	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	3,723	4,159	41,495	9.98	30
31	Medical Records	4,103	5,089	48,381	9.51	31
32	Other Health Care(specify)					32
33	Other(specify) THERAPY NURS	2,066	2,376	50,685	21.33	33
34	TOTAL (lines 1 - 33)	233,988	264,275	$ 3,002,509 *	$ 11.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	187	$ 8,358		35
36	Medical Director	2	150		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600		39
40	Physical Therapy Consultant	9	450		40
41	Occupational Therapy Consultant	17	713		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	14	1,160		45
46	Other(specify)				46
47	WASTE TREATMENT PLANT	48	3,900		47
48	WATER TREATMENT	48	3,020		48
49	TOTAL (lines 35 - 48)	373	$ 18,351		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARY BERGREN		0.00	$ 58,122
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,122

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
DUANE MORRIS	LEGAL FEES	$ 1,781
CLAUDON, LLOYD, BARN	LEGAL FEES	1,080
STATE ATTORNEY	LEGAL FEES	1,590
CIRCLE OF QUALITY	NURSING CONSULTANT	20,179
CMG & COMPANY	COST REPORT/AUDIT	5,800
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 30,430

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 112,679
Unemployment Compensation Insurance	
FICA Taxes	226,269
Employee Health Insurance	311,760
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	79,452
PHYSICALS	40
SERVICE PINS	244
EMPLOYEE RECOGNITION	1,993
LESS: ENTERTAINMENT	(1,993)
TOTAL (agree to Schedule V, line 22, col.8)	$ 730,444

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,646
Health Care Worker Background Check	
(Indicate # of checks performed 70)	555
PUBLIC RELATIONS	4,272
DUES & SUBSCRIPTIONS	2,752
Less: Public Relations Expense	(724)
Non-allowable advertising	(3,547)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,954

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLCREST HOME # 0001099 Report Period Beginning: 12/01/02 Ending: 11/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HILLCREST HOME # 0001099 **Report Period Beginning:** 12/01/02 **Ending:** 11/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. COUNTY NURSING HOME ASSN - $1350

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 40,169 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 98,550
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? YES Indicate the amount. $ 2,545

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: NO The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.